HIPAA DEFINITIONS

1. BUSINESS ASSOCIATE: The Standards for Privacy of Individually Identifiable Health Information Final Rule defines "Business Associate" as follows:

"**(1)** Except as provided in paragraph (2) of this definition, **business associate** means, with respect to a covered entity, a person who:

(i) On behalf of such covered entity or of an organized health care arrangement (as defined in §164.501 of this subchapter) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:

(A) A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or

(B) Any other function or activity regulated by this subchapter; or

(ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement to the person.

(2) A covered entity participating in an organized health care arrangement that performs a function or activity as described in paragraph (1)(i) of this definition for or on behalf of such organized health care arrangement, or that provides a service as described in paragraph (1)(ii) of this definition to or for such organized health care arrangement, does not, simply through the performance of such function or activity or the provision of such service, become a business associate of other covered entities participating in such organized health care arrangement.

(3) A covered entity may be a business associate of another covered entity."

2. CODE SET: The Transaction and Code Sets Regulation defines "Code Set" as "any set of codes used to encode data elements, such as tables of terms, medical concepts, medical

diagnostic codes, or medical procedure codes. A code set includes the codes and descriptors of the codes."

3. CODE SET MAINTAINING ORGANIZATION: The Transaction and Code Sets Regulation defines "Code Set Maintaining Organization" as "an organization that creates and maintains the code sets adopted by the Secretary (HHS) for use in the transactions for which standards are adopted in this part."

4. CORRECTIONAL INSTITUTION: Any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial. The term "correctional institution" includes military confinement facilities, but does not include internment facilities for enemy prisoners of war, retained personnel, civilian detainees and other detainees provided under the provisions of DoD Directive 2310.1 (reference (b)).

5. COVERED ENTITY: The Transaction and Code Sets Regulation and the Standards for Privacy of Individually Identifiable Health Information Regulation defines "Covered Entity" as follows:

"Covered entity means one of the following:

(1) A health plan.

(2) A health care clearinghouse.

(3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter. The DoD *Health Information* Privacy Regulation adds: "In the case of a health plan administered by the Department of Defense, the covered entity is the DoD Component (or subcomponent) that functions as the administrator of the health plan...To the extent this Regulation prescribes duties to be performed by covered entities, the term refers only to DoD covered entities. Not all health care providers affiliated with the Armed Forces are covered entities; among those who are not, are Military Entrance Processing Stations (MEPS) and Reserve units practicing outside of MTFs who do not engage in electronic transactions covered by the regulation."

6. COVERED FUNCTIONS: The DoD *Health Information* Privacy Regulation defines "Covered Functions" as "Those functions of a covered entity the performance of which makes the entity a health plan or health care provider."

7. DATA AGGREGATION: The Privacy Regulation defines "Data Aggregation" as follows: "with respect to protected health information created or received by a business associate in its capacity as the business associate of a covered entity, the combining of such protected health information by the business associate with the protected health information received

by the business associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities."

8. DATA CONDITION: The Transaction and Code Sets Regulation defines "Data Condition" as "the rule that describes the circumstances under which a covered entity must use a particular data element or segment."

9. DATA CONTENT: The Transaction and Code Sets Regulation defines "Data Content" as "all the data elements and code sets inherent to a transaction, and not related to the format of the transaction. Data elements that are related to the format are not data content."

10. DATA ELEMENT: The Transaction and Code Sets Regulation defines "Data Element" as "the smallest named unit of information in a transaction."

11. DATA SET: The Transaction and Code Sets Regulation defines "Data Set" as "a semantically meaningful unit of information exchanged between two parties to a transaction."

12. DE-IDENTIFIED DATA: The Privacy Regulation identifies the following requirements in relationship to "De-Identified Data" as "A covered entity may determine that health information is not individually identifiable health information only if:

(1) A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:

(i) Applying such principles and methods, determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and

(ii) Documents the methods and results of the analysis that justify such determination; or

(2) The following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:

(i) Names;

(ii) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(A) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20, 000 people; and

(B) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(iii) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(iv) Telephone numbers;

(v) Fax numbers;

(vi) Electronic mail addresses;

(vii) Social Security numbers;

(viii) Medical record numbers;

(ix) Health plan beneficiary numbers;

(x) Account numbers;

(xi) Certificate/license numbers;

(xii) Vehicle identifiers and serial numbers, including license plate numbers;

(xiii) Device identifiers and serial numbers;

(xiv) Web Universal Resource Locators (URLs);

(xv) Internet Protocol (IP) address numbers;

(xvi) Biometric identifiers, including finger and voice prints;

(xvii) Full face photographic images and any comparable images; and

(xviii) Any other unique identifying number, characteristic, or code; and

(3) The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

13. DESCRIPTOR: The Transaction and Code Sets Regulation defines "Descriptor" as "the text defining a code."

14. DESIGNATED RECORD SET: The Privacy Regulation defines "Designated Record Set" as the following:

(1) A group of records maintained by or for a covered entity that is:

(i) The medical records and billing records about individuals maintained by or for a covered health care provider;

(ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

(iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals.

(2) For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

15. DESIGNATED STANDARD MAINTENANCE ORGANIZATION (DMSO): The Transaction and Code Sets Regulation defines "Designated Standard Maintenance Organization" as "an organization designated by the Secretary (HHS) under §162.910(a)."

16. DIRECT DATA ENTRY: The Transaction and Code Sets Regulation defines "Direct Data Entry" as "the direct entry of data (for example, using dumb terminals or web browsers) that is immediately transmitted into a health plan's computer."

17. DIRECT TREATMENT RELATIONSHIP: The Privacy Regulation defines *"Direct Treatment Relationship"* as "a treatment relationship between an individual and a health care provider that is not an indirect treatment relationship."

18. DISCLOSURE: The Privacy Regulation defines *"Disclosure"* as "the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information."

19. ELECTRONIC MEDIA: The Transaction and Code Sets Regulation defines "Electronic Media" as "the mode of electronic transmission. It includes the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media."

20. EMPLOYMENT RECORDS: The DoD *Health Information* Privacy Regulation defines *"Employment Records"* as "Records that include health information and that:

(1) Are maintained by a component of the Department of Defense or other entity subject to this Regulation;

(2) Are about an individual who is (or seeks or sought to become) a member of the uniformed services, employee of the United States Government, employee of a

Department of Defense contractor, or person with a comparable relationship to the Department of Defense; and

(3) Are not maintained in connection with carrying out any covered function under this Regulation."

21. FORMAT: The Transaction and Code Sets Regulation defines "Format" as "those data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction."

22. GROUP HEALTH PLAN: The Transaction and Code Sets Regulation and the Privacy Regulation define "Group Health Plan" as follows:

"**Group health plan** (also see definition of **health plan** in this section) means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or trough insurance, reimbursement, or otherwise, that:

(1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or

(2) Is administered by an entity other than the employer that established and maintains the plan."

23. HCPCS: The Transaction and Code Sets Regulation defines "HCPCS" as follows, "HCPCS stands for the Health [Care Financing Administration] Common Procedure Coding System."

24. HHS REGULATION: The DoD *Health Information* Privacy Regulation provides the following definition: "45 CFR Parts 160-164 (reference (d))."

25. HEALTH CARE: The DoD *Health Information* Privacy Regulation defines "Health Care" as "Care, services, or supplies related to the health of an individual. Health care includes but is not limited to, the following:

(1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

(2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription."

26. HEALTH CARE CLEARINGHOUSE: The Privacy Regulation defines "Health Care Clearinghouse" as follows:

"**Health care clearinghouse** means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following functions.

(1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity."

27. HEALTH CARE OPERATIONS: The Privacy Regulation defines "Health Care Operations" as "any of the following activities of the covered entity to the extent that the activities are related to covered functions:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

(3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of §164.514(g) are met, if applicable;

(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

(6) Business management and general administrative activities of the entity, including, but not limited to:

(i) Management activities relating to implementation of and compliance with the requirements of this subchapter;

(ii) Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer.

(iii) Resolution of internal grievances;

(iv) The sale, transfer, merger, or consolidation of all or part of a covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and

(v) Consistent with the applicable requirements of §164.514, creating de-identified health information and fundraising for the benefit of the covered entity.

28. HEALTH CARE PROVIDER: The Transaction and Code Sets Regulation and the Privacy Regulation define "Health Care Provider" as follows:

"**Health care provider** means a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business."

29. HEALTH INFORMATION: The Transaction and Code Sets Regulation and the Privacy Regulation define "Health Information" as follows:

"**Health information** means any information, whether oral or recorded in any form or medium, that:

(1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

30. HEALTH INSURANCE ISSUER: The Transaction and Code Sets Regulation and the Privacy Regulation define "Health Insurance Issuer" as follows:

"**Health insurance issuer** (as defined in section 2791(b) of the PHS Act, 42 U.S.C. 300gg-91(b)(2), and used in the definition of health plan in this section) means an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State Law that regulates insurance. Such term does not include a group health plan."

31. HEALTH MAINTENANCE ORGANIZATION (HMO): The Transaction and Code Sets Regulation and the Privacy Regulation define "Health Maintenance Organization (HMO)" as follows:

"**Health maintenance organization** (HMO) (as defined in section 2791(b)(3) of the PHS Act, 42 U.S.C. 300-gg-91(b)(3) and used in the definition of health plan in this section) means a federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO."

32. HEALTH OVERSIGHT AGENCY: The Privacy Regulation defines "Health Oversight Agency" as "an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant." The DoD *Health Information* Privacy Regulation further states, "The term "health oversight agency" includes any DoD Component authorized under applicable DoD Regulation to oversee the MHS, including with respect to matters of quality of care, risk management, program integrity, financial management, standards of conduct, or the effectiveness of the Military Health System in carrying out its mission."

33. HEALTH PLAN: The DoD *Health Information* Privacy Regulation defines *"Health Plan"* as the following:

"Any DoD program that provides or pays the cost of health care, unless exempted under subparagraphs (3) and (4). The following components of the TRICARE Program are a health plan under this Regulation:

(1) The program that provides health care under the authority of the Department of the Army to members of the uniformed services (Administrator: Surgeon General of the Army.)

(2) The program that provides health care under the authority of the Department of the Navy to members of the uniformed services. (Administrator: Surgeon General of the Navy.)

(3) The program that provides health care under the authority of the Department of the Air Force to members of the uniformed services. (Administrator: Surgeon General of the Air Force.)

(4) The Supplemental Care Program for members of the Army, Navy, Marine Corps, and Air Force who receive health care services from providers other than providers of the Department of Defense. (Administrators: Surgeon General of the Army for members of the Army; Surgeon General of the Navy for members of the Navy and Marine Corps; Surgeon General of the Air Force for members of the Air Force.)

(5) The TRICARE Prime, TRICARE Extra, and TRICARE Standard health care options offered under 32 CFR 199.17 (reference (e)). (Administrator: TRICARE Management Activity.)

(6) The Civilian Health and Medical Program of the Uniformed Services. (Administrator: TRICARE Management Activity.)

(7) The following are also included as health plans:

(a) The TRICARE Dental Program under 10 U.S.C. 1076a (reference (f)). (Administrator: TRICARE Management Activity.)

(b) The TRICARE Retiree Dental Program under 10 U.S.C. 1076c (reference (f)). (Administrator: TRICARE Management Activity.)

(c) The Continued Health Care Benefit Program under 10 U.S.C. 1078a (reference (f)). (Administrator: TRICARE Management Activity.)

(d) The Designated Provider Program under 10 U.S.C. 1073 note (reference (f)). (Administrator: TRICARE Management Activity.)

(e) Programs conducted as demonstration projects under 10 U.S.C. 1092 reference (f)) to the extent not otherwise included under a health plan.

(8) Health plan excludes the following DoD Programs:

(a) Although part of the TRICARE Program, the programs that provide health care in medical and dental treatment facilities of the Departments of the Army, Navy, and Air Force to beneficiaries other than members of the armed forces are excluded by the HHS regulations from the definition of health plan.

(b) The Women, Infants, and Children (WIC) program.

(c) Occupational health clinics for civilian employees or contractor personnel.

(d) Any other policy, plan, or program to the extent that it provides, or pays for the cost of, workers compensation benefits, liability, accident, automobile, or disability income insurance, or similar insurance coverage.

(e) Any other program whose principal purpose is other than providing, or paying the cost of, health care.

(f) Any other program (other than one listed in subparagraphs (1) through (6) above or (7)) whose principal activity is the direct provision of health care to persons.

(g) Any other program whose principal activity is the making of grants to fund the direct provision of health care to persons."

34. INDIRECT TREATMENT RELATIONSHIP: The Privacy Regulation defines "Indirect Treatment Relationship" as "a relationship between an individual and a health care provider in which:

(1) The health care provider delivers health care to the individual based on the orders of another health care provider; and

(2) The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual."

35. INDIVIDUAL: The Privacy Regulation defines the "Individual" as being "the person who is the subject of protected health information."

36. INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION: The Privacy Regulation defines "Individually Identifiable Health Information" as "information that is a subset of health information, including demographic information collected from an individual, and:

(1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(i) That identifies the individual; or

(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual."

37. LAW ENFORCEMENT OFFICIAL: The Privacy Regulation defines "Law Enforcement Official" as "an officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:

(1) Investigate or conduct an official inquiry into a potential violation of law; or

(2) Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

38. LEGACY IDENTIFIER: *Any provider identifier besides the NPI and Federal Tax IDs. Legacy identifiers may include but not be limited to OSCAR, NSC, PINS, UPINS and other identifiers. A Federal Tax ID is not considered a legacy identifier for health care purposes as it's primary purpose is to support IRS 1099 reporting.*

39. LIMITED DATA SET: A limited data set is protected health information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual:

(1) Names;

(2) Postal address information, other than town or city, State, and zip code;

(3) Telephone numbers;

(4) Fax numbers;

(5) Electronic mail addresses;

(6) Social security numbers;

(7) Medical record numbers;

(8) Health plan beneficiary numbers;

(9) Account numbers;

(10) Certificate/license numbers

(11) Vehicle identifiers and serial numbers, including license plate numbers;

(12) Device identifiers and serial numbers;

(13) Web Universal Resource Locators (URLs);

(14) Internet Protocol (IP) address numbers;

(15) Biometric identifiers, including finger and voice prints; and

(16) Full face photographic images and any comparable images.

40. MAINTAIN OR MAINTENANCE: The Transaction and Code Sets Regulation defines "Maintain Or Maintenance" as referring, "to activities necessary to support the use of a standard adopted by the Secretary (HHS), including technical corrections to an implementation specification, and enhancements, or expansion of a code set. This term excludes the activities related to the adoption of a new standard or implementation specification, or modification to an adopted standard or implementation specification."

41. MARKETING: The Privacy Regulation defines "Marketing" as "to make a communication about a product or service to encourage recipients of the communication to purchase or use the product or service. Marketing excludes a communication made to an individual:

(1) To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits;

(2) For the treatment of that individual; or

(3) For case management or care coordination for that individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to that individual."

(4) The DoD Health Information Privacy Regulation adds the following: "To inform an individual who is a member of a uniformed service or a covered beneficiary of the Military Health System of benefits, services, coverages, limitations, costs, procedures, rights, obligations, options, and other information concerning the Military Health System as established by law and applicable regulations;"

42. MAXIMUM DEFINED DATA SET: The Transaction and Code Sets Regulation defines "Maximum Defined Data Set" as "all of the required data elements for a particular standard based on a specific implementation specification."

43. NATIONAL PROVIDER IDENTIFIER (NPI): *The HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers; Final Rule (45 CFR 162), defines "National Provider Identifier" as a standard unique health identifier for health care providers. The NPI format consists of an all numeric identifier, 10 positions in length, with an International Standard Organization (ISO) standard check-digit in the 10th position (§162.406(a)). The NPI will not contain intelligence about the health care provider.*

44. ORGANIZED HEALTH CARE ARRANGEMENT: The DoD Health Information Privacy Regulation indicates that "the MHS is an organized health care arrangement". The Privacy Regulation defines "Organized Health Care Arrangement" as follows:

"**(1)** A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;

(2) An organized system of health care in which more than one covered entity participates, and in which the participating covered entities:

(i) Hold themselves out to the public as participating in a joint arrangement; and

(ii) Participate in joint activities that include at least one of the following:

(A) Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;

(B) Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or

(C) Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

(3) A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to protected health information created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;

(4) A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or

(5) The group health plans described in paragraph (4) of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to protected health information created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans."

45. PAYMENT: The Privacy Regulation defines "Payment" as the following:

(1) The activities undertaken by:

(i) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or

(ii) A covered health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

(2) The activities in paragraph (1) of the definition relate to the individual to whom health care is provided and include, but are not limited to:

(i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

(iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

(v) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

(vi) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:

(A) Name and address;

(B) Date of birth;

(C) Social Security number;

(D) Payment history;

(E) Account number; and

(F) Name and address of the health care provider and/or health plan.

46. PROTECTED HEALTH INFORMATION *(PHI)*: *PHI is information in any format (electronic, paper, oral) that is created or received by a covered entity (health care provider, health plan, or health care clearinghouse that conducts standard electronic transactions). It relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and it identifies the individual, or could be used to identify the individual.*

PHI excludes individually identifiable health information held in employment or educational records.

47. PSYCHOTHERAPY NOTES: The Privacy Regulation defines "Psychotherapy Notes" as "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date."

48. PUBLIC HEALTH AUTHORITY: The Privacy Regulation defines "Public Health Authority" as "an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate." The DoD Health Information Privacy Regulation adds "The term "public health authority" includes any DoD Component authorized under applicable DoD regulation to carry out public health activities, including medical surveillance activities under DoD Directive 6490.2 (reference (g)).

49. REQUIRED BY LAW: The Privacy Regulation defines "Required By Law" to mean "a mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits." The DoD Health Information Privacy Regulation specifies the following: "Required by law includes

any mandate contained in a DoD Regulation that requires a covered entity (or other person functioning under the authority of a covered entity) to make a use or disclosure and is enforceable in a court of law. The attribute of being enforceable in a court of law means that in a court or court-martial proceeding, a person required by the mandate to comply would be held to have a legal duty to comply or, in the case of noncompliance, to have had a legal duty to have complied. Required by law also includes any DoD regulation requiring the production of information necessary to establish eligibility for reimbursement or coverage under TRICARE/CHAMPUS.

50. RESEARCH: The DoD Health Information Privacy Regulation provides the following definition: "A systematic investigation, including research, development, testing, and evaluation, designed to develop or contribute to generalizable knowledge."

51. SECRETARY OF HEALTH AND HUMAN SERVICES: The DoD Health Information Privacy Regulation provides the following definition: "The Secretary of Health and Human Services or any other officer or employee of HHS to whom the relevant authority has been delegated.

52. SEGMENT: The Transaction and Code Sets Regulation defines "Segment" as "a group of related data elements in a transaction."

53. STANDARD TRANSACTION: The Transaction and Code Sets Regulation defines "Standard Transaction" as "a transaction that complies with the applicable standard adopted under this part."

54. STATE: The DoD Health Information Privacy Regulation defines "State" as "One of the following:

> For a health plan established or regulated by Federal law, State has the meaning set forth in the applicable section of the United States Code for such health plan.
>
> For all other purposes, State means any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam."

55. SUMMARY HEALTH INFORMATION: The Privacy Regulation defines "Summary Health Information" as "information, that may be individually identifiable health information, and:

> **(1)** That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and
>
> **(2)** From which the information described at §164.514(b)(2)(i) has been deleted, except that the geographic information described in §164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code."

56. TRADING PARTNER AGREEMENT: The Transaction and Code Sets Regulation and the Privacy Regulation define "Trading Partner Agreement" as follows:

"**Trading partner agreement** means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement,

between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)"

57. TRANSACTION: The Transaction and Code Sets Regulation and the Privacy Regulation define "Transaction" as follows:

"**Transaction** means the transmission of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

(1) Health care claims or equivalent encounter information.

(2) Health care payment and remittance advice.

(3) Coordination of benefits.

(4) Health care claims status.

(5) Enrollment and disenrollment in a health plan.

(6) Eligibility for a health plan.

(7) Health plan premium payments.

(8) Referral certification and authorization.

(9) First report of injury.

(10) Health claims attachments.

(11) Other transactions that the Secretary may prescribe by regulation.

58. TREATMENT: The Privacy Regulation defines "Treatment" as the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

59. USE: The Privacy Regulation defines "Use" as "with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information."

60. WORKFORCE: The Privacy Regulation defines, "Workforce" as "employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity is under the direct control of such entity, whether or not they are paid by the covered entity."